Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA Alaska HCS & RO - 463

VISN 20

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 450

2. Point-in-time estimate of Veterans who are Chronically Homeless: 120

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **450** (point-in-time estimate of homeless veterans in service area) **X 33%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 80%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 120** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	360	0
Transitional Housing Beds	30	12
Permanent Housing Beds	150	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Clothing	Work with Municipality of Anchorage Homeless Services to identify homeless veteran population and clothing needs. Continue to network with Anchorage service providers to increase community awareness of programs available to veterans through Homeless Veterans Service and Health Care for Homeless Veterans.
Transitional living facility	Continue to network with Anchorage service providers to identify creative ways to provide transitional housing in the greater Anchorage area. Explore possible partnerships with interested and responsible non-profits -- to include supporting the VA grant application process with these non-profits. A local non-profit is buying and renovating a hotel to house veterans who fly in from rural Alaska to access VA services.
Clothing	Work with the Municipality of Anchorage Homeless Services to identify homeless veteran population basic needs. Continue outreach efforts in partnership with Brother Francis Shelter to provide counseling and referrals.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 27 Non-VA staff Participants: 92%
Homeless/Formerly Homeless: 4%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2	36%	2.25	1
2	Treatment for dual diagnosis	2.39	0%	3.01	18
3	Halfway house or transitional living facility	2.5	14%	2.76	8
4	Job training	2.5	36%	2.88	14
5	Dental care	2.54	0%	2.34	2
6	Detoxification from substances	2.56	7%	3.11	22
7	Education	2.62	7%	2.88	13
8	Legal assistance	2.62	7%	2.61	4
9	Help managing money	2.67	0%	2.71	7
10	Guardianship (financial)	2.69	0%	2.76	9
11	Help with finding a job or getting employment	2.69	21%	3.00	17
12	Drop-in center or day program	2.71	0%	2.77	10
13	Child care	2.71	0%	2.39	3
14	Treatment for substance abuse	2.72	21%	3.30	28
15	Services for emotional or psychiatric problems	2.72	7%	3.20	25
16	AIDS/HIV testing/counseling	2.76	0%	3.38	30
17	Family counseling	2.81	0%	2.85	12
18	Help with transportation	2.81	0%	2.82	11
19	Emergency (immediate) shelter	2.83	21%	3.04	20
20	TB testing	2.88	0%	3.58	36
21	TB treatment	2.88	0%	3.45	33
22	Discharge upgrade	2.92	0%	2.90	15
23	SSI/SSD process	2.93	0%	3.02	19
24	Help getting needed documents or identification	2.93	0%	3.16	23
25	Glasses	3	0%	2.67	6
26	Women's health care	3.07	0%	3.09	21
27	Eye care	3.08	0%	2.65	5
28	VA disability/pension	3.08	0%	3.33	29
29	Welfare payments	3.08	7%	2.97	16
30	Personal hygiene (shower, haircut, etc.)	3.13	0%	3.21	26
31	Clothing	3.13	0%	3.40	31
32	Hepatitis C testing	3.14	0%	3.41	32
33	Food	3.35	7%	3.56	35
34	Help with medication	3.37	0%	3.18	24
35	Spiritual	3.42	0%	3.30	27
36	Medical services	3.59	0%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.14	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.09	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.63	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.95	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.53	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.6	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.17	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.24	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.09	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.61	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.57	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.76	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.19	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.14	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.27	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.45	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.27	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.09	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.29	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.24	1.84

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CHALENG 2004 Survey: VA DOM White City, OR - 692

VISN 20

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 320

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **320** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	115	50
Transitional Housing Beds	90	100
Permanent Housing Beds	370	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 13

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Pursue Per Diem certification and implementation. Continue to encourage development of services and support existing programs.
Long-term, permanent housing	Pursue new 50-bed, residential care facility, supporting construction phase and implementation. Continue to encourage development of services and support existing programs: I.e., "Home-at-Last" scattered leasing program.
Detoxification from substances	Continue to work with the local county government to encourage privatizing of detox services; continue discussion with two separate community-based agencies.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 19 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 5%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	1.21	6%	2.39	3
2	Long-term, permanent housing	1.26	50%	2.25	1
3	Dental care	1.32	6%	2.34	2
4	Eye care	1.32	0%	2.65	5
5	Discharge upgrade	1.39	0%	2.90	15
6	Glasses	1.42	0%	2.67	6
7	Guardianship (financial)	1.47	6%	2.76	9
8	Halfway house or transitional living facility	1.58	50%	2.76	8
9	Drop-in center or day program	1.58	0%	2.77	10
10	Help managing money	1.58	0%	2.71	7
11	Help with medication	1.63	0%	3.18	24
12	Detoxification from substances	1.68	33%	3.11	22
13	Treatment for dual diagnosis	1.68	0%	3.01	18
14	Welfare payments	1.68	0%	2.97	16
15	Legal assistance	1.74	11%	2.61	4
16	Help with transportation	1.84	0%	2.82	11
17	Women's health care	1.95	11%	3.09	21
18	Education	2	0%	2.88	13
19	Services for emotional or psychiatric problems	2.05	6%	3.20	25
20	Family counseling	2.05	0%	2.85	12
21	AIDS/HIV testing/counseling	2.11	0%	3.38	30
22	TB treatment	2.16	0%	3.45	33
23	Emergency (immediate) shelter	2.21	0%	3.04	20
24	TB testing	2.21	0%	3.58	36
25	Hepatitis C testing	2.21	0%	3.41	32
26	Help getting needed documents or identification	2.21	0%	3.16	23
27	SSI/SSD process	2.26	6%	3.02	19
28	Personal hygiene (shower, haircut, etc.)	2.37	0%	3.21	26
29	Job training	2.37	6%	2.88	14
30	Help with finding a job or getting employment	2.42	0%	3.00	17
31	Clothing	2.47	0%	3.40	31
32	Spiritual	2.53	0%	3.30	27
33	Treatment for substance abuse	2.74	11%	3.30	28
34	Medical services	2.74	0%	3.55	34
35	Food	3.05	0%	3.56	35
36	VA disability/pension	3.26	0%	3.33	29

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	2.89	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.74	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.18	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.38	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.21	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.21	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.6	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.6	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.56	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.5	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.28	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.61	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.06	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.33	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.11	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.47	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.22	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.17	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.17	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.06	1.84

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CHALENG 2004 Survey: VA Puget Sound HCS (VAMC American Lake - 663A4 and VAMC Seattle, WA - 663), Tacoma, WA

VISN 20

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 2400

2. Point-in-time estimate of Veterans who are Chronically Homeless: 975

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **2400** (point-in-time estimate of homeless veterans in service area) **X 52%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 78%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 975** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	229	150
Transitional Housing Beds	200	150
Permanent Housing Beds	30	400

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Advocacy for Section 8 vouchers replacement/funding. Explore alternative funding sources.
Transitional living facility	Support existing VA Grant and Per Diem Program. Encourage new applications.
Dental Care	Fully support existing program. Seek grants.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 31 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 6%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.68	26%	2.25	1
2	Emergency (immediate) shelter	1.84	45%	3.04	20
3	Halfway house or transitional living facility	1.84	39%	2.76	8
4	Treatment for dual diagnosis	2.13	6%	3.01	18
5	Dental care	2.14	0%	2.34	2
6	Drop-in center or day program	2.27	3%	2.77	10
7	Help with medication	2.32	0%	3.18	24
8	Child care	2.32	3%	2.39	3
9	Treatment for substance abuse	2.35	6%	3.30	28
10	Help managing money	2.36	3%	2.71	7
11	Family counseling	2.37	3%	2.85	12
12	Legal assistance	2.41	3%	2.61	4
13	Services for emotional or psychiatric problems	2.42	10%	3.20	25
14	Job training	2.46	0%	2.88	14
15	Detoxification from substances	2.48	6%	3.11	22
16	Glasses	2.48	0%	2.67	6
17	Help with transportation	2.48	0%	2.82	11
18	Help with finding a job or getting employment	2.5	6%	3.00	17
19	Discharge upgrade	2.52	0%	2.90	15
20	Eye care	2.55	0%	2.65	5
21	Women's health care	2.67	0%	3.09	21
22	Personal hygiene (shower, haircut, etc.)	2.73	3%	3.21	26
23	SSI/SSD process	2.77	3%	3.02	19
24	Help getting needed documents or identification	2.79	0%	3.16	23
25	Clothing	2.84	0%	3.40	31
26	Welfare payments	2.86	3%	2.97	16
27	Spiritual	2.86	0%	3.30	27
28	Guardianship (financial)	2.9	10%	2.76	9
29	Education	2.9	3%	2.88	13
30	AIDS/HIV testing/counseling	3.07	3%	3.38	30
31	Hepatitis C testing	3.07	3%	3.41	32
32	VA disability/pension	3.07	3%	3.33	29
33	Medical services	3.1	0%	3.55	34
34	Food	3.32	0%	3.56	35
35	TB treatment	3.34	0%	3.45	33
36	TB testing	3.41	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	2.74	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.55	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.23	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.52	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.26	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.48	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.61	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.03	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.17	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.47	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.57	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.55	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.34	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.31	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.21	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.57	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.33	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.43	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.4	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.68	1.84

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CHALENG 2004 Survey: VA Roseburg HCS, OR - 653 (Eugene, OR)

VISN 20

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 4800

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1898

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **4800** (point-in-time estimate of homeless veterans in service area) **X 44%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 89%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1898** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	450	300
Transitional Housing Beds	287	250
Permanent Housing Beds	110	150

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 15

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Continue to apply for grants, other financial options and encourage the establishment of more Oxford and residential recovery houses to be set up. Work in tandem with local homeless coalition. Encourage more interaction with local law enforcement.
Immediate shelter	Continue to work with local homeless coalition and HUD to seek funding for more permanent housing. Apply for grants and publicize need for donated housing.
Long-term, permanent housing	Work more closely with existing shelter site regarding expansion of beds. Encourage other faith-based agencies to apply for grants aimed at locating more shelter beds in other parts of town.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 13 Non-VA staff Participants: 23%
Homeless/Formerly Homeless: 8%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2	0%	2.39	3
2	Legal assistance	2	0%	2.61	4
3	Drop-in center or day program	2.09	8%	2.77	10
4	Dental care	2.09	8%	2.34	2
5	Help managing money	2.11	0%	2.71	7
6	Long-term, permanent housing	2.18	23%	2.25	1
7	Glasses	2.55	0%	2.67	6
8	Emergency (immediate) shelter	2.58	38%	3.04	20
9	Halfway house or transitional living facility	2.58	54%	2.76	8
10	Guardianship (financial)	2.63	0%	2.76	9
11	Help with transportation	2.7	0%	2.82	11
12	Eye care	2.8	8%	2.65	5
13	Education	2.8	0%	2.88	13
14	Family counseling	2.82	0%	2.85	12
15	Welfare payments	2.89	0%	2.97	16
16	Job training	2.9	0%	2.88	14
17	Personal hygiene (shower, haircut, etc.)	2.92	8%	3.21	26
18	Food	3.08	15%	3.56	35
19	Clothing	3.09	0%	3.40	31
20	SSI/SSD process	3.1	0%	3.02	19
21	Help with finding a job or getting employment	3.1	0%	3.00	17
22	Help getting needed documents or identification	3.1	0%	3.16	23
23	Detoxification from substances	3.18	0%	3.11	22
24	Women's health care	3.2	0%	3.09	21
25	Discharge upgrade	3.22	0%	2.90	15
26	Spiritual	3.25	8%	3.30	27
27	Treatment for dual diagnosis	3.3	0%	3.01	18
28	Help with medication	3.36	0%	3.18	24
29	Services for emotional or psychiatric problems	3.5	8%	3.20	25
30	AIDS/HIV testing/counseling	3.56	0%	3.38	30
31	VA disability/pension	3.6	8%	3.33	29
32	Medical services	3.64	8%	3.55	34
33	TB testing	3.7	8%	3.58	36
34	TB treatment	3.8	0%	3.45	33
35	Treatment for substance abuse	3.82	0%	3.30	28
36	Hepatitis C testing	4	0%	3.41	32

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.46	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.31	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.27	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.67	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.75	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.5	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.83	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.58	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.4	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	3	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.25	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.8	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.8	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.2	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.8	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	3	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.75	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Boise, ID - 531

VISN 20

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 300

2. Point-in-time estimate of Veterans who are Chronically Homeless: 34

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **300** (point-in-time estimate of homeless veterans in service area) **X 14%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 79%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 34** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	100	25
Transitional Housing Beds	30	20
Permanent Housing Beds	10	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Detoxification from substances	Continue to work with homeless coalition and other providers to develop/identify detox beds and facilities. Improve access to these.
Treatment for substance abuse	Work with area providers to identify and access treatment beds. Work with coalition to increase number of treatment slots by community education and advocacy.
Transitional living facility	Work with Boise City to access/utilize VA Grant and Per Diem funding.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 6 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 17%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Treatment for substance abuse	1.5	17%	3.30	28
2	Detoxification from substances	1.67	33%	3.11	22
3	Services for emotional or psychiatric problems	1.67	0%	3.20	25
4	SSI/SSD process	1.8	0%	3.02	19
5	Treatment for dual diagnosis	2	0%	3.01	18
6	Guardianship (financial)	2	0%	2.76	9
7	Job training	2	0%	2.88	14
8	Child care	2	0%	2.39	3
9	Halfway house or transitional living facility	2.17	33%	2.76	8
10	Family counseling	2.17	0%	2.85	12
11	Help managing money	2.17	0%	2.71	7
12	Eye care	2.2	0%	2.65	5
13	Glasses	2.2	0%	2.67	6
14	Dental care	2.4	0%	2.34	2
15	Welfare payments	2.4	0%	2.97	16
16	Help getting needed documents or identification	2.4	17%	3.16	23
17	Legal assistance	2.4	0%	2.61	4
18	Long-term, permanent housing	2.5	0%	2.25	1
19	Medical services	2.5	0%	3.55	34
20	Help with medication	2.5	0%	3.18	24
21	Drop-in center or day program	2.5	0%	2.77	10
22	Help with finding a job or getting employment	2.5	0%	3.00	17
23	Emergency (immediate) shelter	2.6	83%	3.04	20
24	Education	2.6	0%	2.88	13
25	Women's health care	2.67	0%	3.09	21
26	Help with transportation	2.67	0%	2.82	11
27	TB testing	2.8	0%	3.58	36
28	TB treatment	2.8	0%	3.45	33
29	Personal hygiene (shower, haircut, etc.)	3	0%	3.21	26
30	AIDS/HIV testing/counseling	3	0%	3.38	30
31	Hepatitis C testing	3	0%	3.41	32
32	VA disability/pension	3	0%	3.33	29
33	Food	3.17	0%	3.56	35
34	Discharge upgrade	3.2	0%	2.90	15
35	Spiritual	3.4	17%	3.30	27
36	Clothing	3.5	17%	3.40	31

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.67	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.17	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.6	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.4	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.33	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.33	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.17	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.33	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.33	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.17	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.5	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Portland, OR - 648

VISN 20

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1700

2. Point-in-time estimate of Veterans who are Chronically Homeless: 349

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1700** (point-in-time estimate of homeless veterans in service area) **X 28%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 74%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 349** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	140
Transitional Housing Beds	183	30
Permanent Housing Beds	75	5

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue efforts with Community Partners for Affordable Housing in Portland, Oregon, to develop seven additional SEPA. Long-term, Section 8, project-based, senior housing units.
Transitional living facility	Currently enhancing alliance with Central City Concerns to finalize 50 VA Grant and Per Diem housing slots to meet increased transitional housing need.
Help with Transportation	We have recently enhanced access to Clark County veterans funds and shared resources for bus tokens and passes between VAMC, Central City Concerns, and State Employment Offices. Continue VA Vocational Rehabilitation assistance with DMV to clear up outstanding matters and lay ground work for reinstatement of licenses. Work with Transit Systems (OR/WA) to expedite honored citizens discount bus passes.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 28 Non-VA staff Participants: 64% Homeless/Formerly Homeless: 11%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	1.63	21%	2.34	2
2	Long-term, permanent housing	1.89	38%	2.25	1
3	Legal assistance	2.08	0%	2.61	4
4	Glasses	2.16	0%	2.67	6
5	Eye care	2.25	0%	2.65	5
6	Help with transportation	2.28	8%	2.82	11
7	Child care	2.43	0%	2.39	3
8	Halfway house or transitional living facility	2.44	21%	2.76	8
9	Emergency (immediate) shelter	2.48	8%	3.04	20
10	Welfare payments	2.5	0%	2.97	16
11	SSI/SSD process	2.5	0%	3.02	19
12	Help managing money	2.52	8%	2.71	7
13	Family counseling	2.54	0%	2.85	12
14	Drop-in center or day program	2.56	0%	2.77	10
15	Education	2.68	8%	2.88	13
16	Help with medication	2.69	8%	3.18	24
17	Treatment for dual diagnosis	2.78	4%	3.01	18
18	Guardianship (financial)	2.78	0%	2.76	9
19	Personal hygiene (shower, haircut, etc.)	2.81	4%	3.21	26
20	Discharge upgrade	2.88	0%	2.90	15
21	Medical services	2.93	0%	3.55	34
22	Services for emotional or psychiatric problems	2.96	4%	3.20	25
23	Detoxification from substances	3	4%	3.11	22
24	Treatment for substance abuse	3.04	13%	3.30	28
25	Women's health care	3.04	0%	3.09	21
26	Job training	3.08	8%	2.88	14
27	VA disability/pension	3.12	4%	3.33	29
28	Clothing	3.15	8%	3.40	31
29	Help getting needed documents or identification	3.16	0%	3.16	23
30	AIDS/HIV testing/counseling	3.17	0%	3.38	30
31	Hepatitis C testing	3.25	0%	3.41	32
32	Help with finding a job or getting employment	3.28	17%	3.00	17
33	TB treatment	3.44	0%	3.45	33
34	Spiritual	3.5	0%	3.30	27
35	Food	3.7	8%	3.56	35
36	TB testing	3.72	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.16	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.16	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.36	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.74	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.71	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.87	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.29	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.29	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.79	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.28	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.11	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.74	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.89	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.95	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.89	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.53	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.05	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.89	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.05	1.84

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CHALENG 2004 Survey: VAMC Spokane, WA - 668

VISN 20

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 3600

2. Point-in-time estimate of Veterans who are Chronically Homeless: 734

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **3600** (point-in-time estimate of homeless veterans in service area) **X 25%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 82%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 734** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	660	50
Transitional Housing Beds	40	0
Permanent Housing Beds	16	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 35

3. CHALENG Point of Contact Action Plan for FY 2005

Services for emotional or psychiatric problems	New psychiatrist has been hired and will spend some of his time with substance abuse treatment and homeless. No new support staff have been hired to work with veterans.
Women's Health Care	Inroads have been established with Vet Outreach Center. Will work with community resources to develop alternative access.
Dental Care	Although we have had some success with acute access, ongoing care and treatment are still a problem. VA dental clinic is tasked with treating returning Iraqi veterans and has not been able to routinely address homeless veteran issues.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 47 Non-VA staff Participants: 73% Homeless/Formerly Homeless: 49%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.38	20%	2.34	2
2	Child care	2.45	0%	2.39	3
3	Treatment for dual diagnosis	2.47	22%	3.01	18
4	Long-term, permanent housing	2.53	20%	2.25	1
5	Family counseling	2.64	4%	2.85	12
6	Women's health care	2.71	9%	3.09	21
7	Legal assistance	2.76	2%	2.61	4
8	Help with finding a job or getting employment	2.91	11%	3.00	17
9	Guardianship (financial)	2.96	0%	2.76	9
10	Job training	2.96	7%	2.88	14
11	SSI/SSD process	3	4%	3.02	19
12	Spiritual	3.05	4%	3.30	27
13	Drop-in center or day program	3.07	2%	2.77	10
14	Eye care	3.09	2%	2.65	5
15	Glasses	3.09	0%	2.67	6
16	Welfare payments	3.09	2%	2.97	16
17	Help managing money	3.11	4%	2.71	7
18	Discharge upgrade	3.11	0%	2.90	15
19	Education	3.17	7%	2.88	13
20	Help with transportation	3.2	2%	2.82	11
21	Halfway house or transitional living facility	3.28	13%	2.76	8
22	Emergency (immediate) shelter	3.45	16%	3.04	20
23	Services for emotional or psychiatric problems	3.45	7%	3.20	25
24	VA disability/pension	3.45	13%	3.33	29
25	Personal hygiene (shower, haircut, etc.)	3.6	0%	3.21	26
26	TB testing	3.65	0%	3.58	36
27	TB treatment	3.65	0%	3.45	33
28	Detoxification from substances	3.66	4%	3.11	22
29	Help getting needed documents or identification	3.66	2%	3.16	23
30	AIDS/HIV testing/counseling	3.69	0%	3.38	30
31	Medical services	3.72	0%	3.55	34
32	Help with medication	3.74	2%	3.18	24
33	Clothing	3.87	2%	3.40	31
34	Treatment for substance abuse	3.93	7%	3.30	28
35	Hepatitis C testing	3.94	2%	3.41	32
36	Food	3.96	7%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.81	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.23	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.89	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.7	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.06	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.77	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.85	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.64	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.29	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.69	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.29	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.71	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.5	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.36	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.86	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.57	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.07	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.21	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.14	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC Walla Walla, WA - 687

VISN 20

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 395

2. Point-in-time estimate of Veterans who are Chronically Homeless: 107

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **395** (point-in-time estimate of homeless veterans in service area) **X 39%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 69%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 107** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	37	30
Transitional Housing Beds	20	7
Permanent Housing Beds	20	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Dental Care	Utilize VA Dental Services under VHA 2002-080. Use dental van at next Stand Down and visits at Yakima. Use Washington State Dept. of Veteran Affairs funds for dental visits.
Transitional living facility	Refer veterans to Yakima transitional house. Discuss possibility of starting Oxford House in Walla Walla.
Long-term, permanent housing	Seek Section 8 vouchers from Walla Walla. Meet with Walla Walla Renters Association and VA Mental Health Services to increase access to low-income housing. Endorse Walla Walla ten-year plan to end homelessness.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 25 Non-VA staff Participants: 72% Homeless/Formerly Homeless: 40%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.27	21%	2.34	2
2	Child care	2.53	5%	2.39	3
3	Drop-in center or day program	2.56	5%	2.77	10
4	Legal assistance	2.75	5%	2.61	4
5	Eye care	2.86	5%	2.65	5
6	Long-term, permanent housing	2.92	37%	2.25	1
7	Women's health care	2.94	16%	3.09	21
8	Guardianship (financial)	3	0%	2.76	9
9	Glasses	3.05	0%	2.67	6
10	Family counseling	3.09	0%	2.85	12
11	SSI/SSD process	3.11	0%	3.02	19
12	Help managing money	3.11	0%	2.71	7
13	Treatment for dual diagnosis	3.17	0%	3.01	18
14	Welfare payments	3.22	0%	2.97	16
15	Services for emotional or psychiatric problems	3.26	21%	3.20	25
16	Emergency (immediate) shelter	3.36	21%	3.04	20
17	Job training	3.37	5%	2.88	14
18	Discharge upgrade	3.41	0%	2.90	15
19	Education	3.42	5%	2.88	13
20	Help with medication	3.45	0%	3.18	24
21	Help with transportation	3.6	0%	2.82	11
22	Spiritual	3.63	5%	3.30	27
23	Clothing	3.65	0%	3.40	31
24	VA disability/pension	3.68	0%	3.33	29
25	AIDS/HIV testing/counseling	3.7	0%	3.38	30
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